

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155359		X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2011	
NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER ROAD FORT WAYNE, IN46819			
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F0000	<p>This visit was for the investigation of Complaints #IN00086999 and Complaint #IN00087008. This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint # IN00086999 substantiated, Federal/State deficiencies related to the allegations are cited at F309, F 323, and F 425.</p> <p>Complaint # IN00087008 substantiated, Federal/State deficiencies related to the allegation are cited at F 441.</p> <p>Survey dates: March 8, 9, 10, 2011 Extended survey dates: March 11, 12, 13,14, 2011</p> <p>Facility number: 000250 Provider number: 155359</p>			F0000	<p>Preparation or execution of the plan of correction (POC) does not constitute admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the Statement of Deficiencies (SOD). The POC is prepared and executed solely because it is required by law.</p> <p>By this response, Riverbend Health Care Center acknowledges receipt of the SOD and alleges that it is in compliance. Accordingly, the POC is submitted as alleged compliance as of April 13, 2011.</p> <p>Riverbend Health Care Center reserves the right to submit documentation to refute any of the stated deficiencies on the SOD through formal appeal and or other administrative or legal proceedings.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2011

FORM APPROVED

OMB NO. 0938-0391

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	Aim number: 100289980 Survey team: Ann Armey, RN TC March 8,9,10,13,14/2011 Diane Nilson, RN March 8,9,10,11,12/2010 Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 6 Medicaid: 40 Other: 2 Total: 48 Sample: 7 Supplemental sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.						

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F0309 SS=J	<p>Based on interviews and record review, the facility failed to assess a 3rd degree burn for 3.5 hours, failed to provide a follow-up assessment of a resident with a low blood sugar and failed to immediately notify the physician regarding low blood sugars and a 3rd degree burn. This deficiency affected 1 of 5 residents with in insulin dependent diabetes mellitus and 1 of 1 resident who sustained a 3rd degree burn in a sample of 7. This resulted in resident B requiring hospitalization, wound vac treatment, and planned future grafting to the burn site. (Resident #B)</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 3/10/11 and began on 1/18/11. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 3/10/11. The Immediate Jeopardy was removed on 3/14/11, but the facility</p>			F0309	<p>Preparation or execution of the plan of correction (POC) does not constitute admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the Statement of Deficiencies (SOD). The POC is prepared and executed solely because it is required by law. By this response, Riverbend Health Care Center acknowledges receipt of the SOD and alleges that it is in compliance. Accordingly, the POC is submitted as alleged compliance as of April 13, 2011. Riverbend Health Care Center reserves the right to submit documentation to refute any of the stated deficiencies on the SOD through formal appeal and or other administrative or legal proceedings.F 309 SS=J Provide care/services for highest well being 1. The Facility is unable to apply specific corrective actions as the resident identified no longer resides at the facility. Charge Nurse no longer works at facility. 2. Residents who are insulin dependant diabetics have been identified. 15 out of 15 insulin dependant diabetic residents had their blood sugar checked and residents whose blood sugar was not within normal limits were referred to the physician for further review as indicated on March 10, 2011 and their insulin orders were adjusted if needed. 15 out of 15 insulin</p>		04/13/2011

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	<p>remained out of compliance at the level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>Upon interview 3/8/11 at 9:45 a.m., during the entrance conference, the Administrator indicated there had been a reportable incident involving resident #B in January 2011. The Administrator indicated Resident #B had a low blood sugar, fell and burned his hand on the heater in his room. The Administrator indicated the resident had been sent to the hospital burn unit and did not return to the facility.</p> <p>The clinical record of resident #B was reviewed on 3/8/11 at 11:00 a.m. and indicated the resident was admitted to the facility on 1/10/11, with diagnoses which included, but were not limited to, transmetatarsal amputation of the right foot for</p>				<p>dependant diabetic residents had their insulin orders with parameters reviewed by the Nursing Management Team on March 10, 2011. 47 out of 47 residents had a skin assessment completed by March 11, 2011 and there were no other residents identified with a burn. 3. Omnicare Pharmacy Clinical Nurse Consultant conducted onsite training to DON, and Regional Quality Specialist on Diabetic management on March 11, 2011. DON and Regional Quality Specialist (RQS) re-educated licensed nursing staff on Diabetic Management, Facility policy & procedure related to diabetic management and when to notify physician related to diabetic management. The DON or designee will continue ongoing training with licensed staff and new hired licensed staff on orientation. The DON and RQS have re-educated licensed nursing staff on identification of all 4 stages of burns. The DON or designee has re-educated licensed staff on facility policy and policy related to physician notification. The DON will continue ongoing training to licensed nursing staff and new hire licensed nursing staff specific to identification and s/sx of burns and return verbalization will be conducted to determine licensed nursing staff knowledge of burns. The DON or designee will</p>		

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	<p>poliomyelitis and insulin dependent diabetes mellitus.</p> <p>Admission orders, dated 1/10/11, indicated Resident #B was to have his blood sugars checked four times per day at 6:30 a.m., 11:30 a.m., 5:30 p.m. and 8:00 p.m. The resident was to receive Novolog insulin before meals based on his blood sugars levels as follows: 110-150= 2 units 151-200= 4 units 201-250= 6 units 251-300= 8 units. Call MD if > [greater than] 300 Admission orders further indicated the resident was to receive 18 units of Lantus insulin at bedtime. The Lantus insulin was discontinued on 1/11/11 and Starlix (an oral medication used to lower blood glucose) 120 mg [milligrams] was ordered three times per day with meals. The January MAR (medication administration record) indicated the Starlix was given at 7:00 a.m., 12 noon and 6:00 p.m.).</p>				<p>review the 24 hour report for any changes in condition or incident through the daily clinical meeting and additional assessments will be completed as indicated. 4. Addendum: The DON or designee will conduct QA rounds 3x's weekly for 4 weeks, weekly for 4 weeks, and then monthly thereafter, to ensure that Diabetic residents have parameters for management of hypo and hyperglycemia that the appropriate action has been completed by nurse related to FBS and daily finger sticks and that MD has been notified per policy. Addendum: DON or designee will conduct QA rounds of resident's skin to determine if any burns like concerns are noted 3x's weekly for 4 weeks, once weekly for 4 weeks, and then monthly thereafter. Addendum: The results of these QA rounds will be addressed immediately by the DON or designee and reviewed at the Facility Risk Management Quality Improvement (RMQI) program for evaluation and revisions as indicated to prevent further occurrences. Completion date: April 13, 2011.</p>		

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	<p>There were no orders regarding what measures were to be taken if the resident had low blood sugars.</p> <p>On 1/15/11 at 11:00 a.m., the diabetic flow sheet indicated Resident #B had a low blood sugar of 44. An entry beside the 44 ("44/130") measurement indicated the Resident's blood sugar had been retaken, and was 130.</p> <p>There was no documentation the physician was notified about the low blood sugar.</p> <p>During interview on 3/10/11 at 9:00 a.m. the DON (Director of Nursing) indicated she was not able to determine if the physician had been notified about the low blood sugar on 1/15/11.</p> <p>On 1/18/11 at 6:00 a.m., the diabetic flow sheet indicated Resident #B had a blood sugar of 151 and 4 units of Novolog insulin were administered.</p>						

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	<p>On 1/18/11 at 8:00 a.m., Nursing notes indicated, "Called to room per CNA et (and) med. (medical) records. Observed res. (resident) on floor between bed and window Rt (right) hand up against the register. Full ROM (range of motion). No c/o (complaints) of pain. res assisted back to w/c (wheelchair) et charge nurse entered room et began v/s (vital signs). Hand appeared s (without) redness was hard white area between thumb et 1st finger." On 1/18/11 between 8:01 and 8:04 a.m., nursing notes indicated vital signs were taken and further indicated "Writer entered res room res on floor by window, diaphoretic. res B.S. (blood sugar) checked BS 51 protein supplement given breakfast here assisted with breakfast by staff. Scheduled transport here LOA (leave of absence) scheduled apt (appointment); (Dr name) called and NO (new order) received & (and) Noted.</p>						

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	<p>On 1/18/11 at 10:30 a.m., Physician orders were received to discontinue Starlix 120 mg three times daily and start Starlix 60 mg three times daily.</p> <p>On 1/18/11 at 11:00 a.m., a physician's order indicated "R (right) hand burn, send to burn unit [name of hospital documented] Hospital wound care."</p> <p>On 3/8/11 at 11:55 a.m., the medical records/van driver was interviewed about the incident with resident #B on 1/18/11.</p> <p>The medical records staff person indicated she was working on 1/18/11 and heard CNA #1 yelling for help so she ran to Resident #B's room. The medical records person indicated the resident was "out of it", lying on his right side with the index finger of his right hand in the gap of the heater and his thumb touching the heater.</p> <p>The medical records person indicated she took the hand out of</p>						

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	<p>the heater and called for assistance.</p> <p>The medical records person indicated LPN #2 and the charge nurse, LPN #3 arrived, checked the resident, and they lifted him into his wheelchair. She indicated Resident #B did not remember how he got on the floor and he had a white area on his right hand along the thumb and index finger which LPN #2 checked and thought was a callous.</p> <p>The medical records person indicated at around 9:00 a.m., she took the resident to an appointment at [name of Orthopedics center documented). She indicated Resident #B said he didn't feel well so she called the facility, the DON and Corporate nurse arrived at the orthopedics center and the corporate nurse put some ointment on Resident #B's hand and wrapped it. According to the medical records person, the orthopedics center Doctor did not look at the resident's hand.</p> <p>CNA #1, who provided care to</p>						

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	<p>Resident #B on 1/18/11, was interviewed on 3/8/11 at 1:30 p.m. CNA #1 indicated at 7:30 a.m. she saw the resident sitting on the edge of his bed, facing the door, dressed. The aide indicated she was passing room trays at around 7:45 a.m. and noticed the resident was not in his room so she put the tray back in the cart. She indicated she looked in the Resident's bathroom and when she turned around, she saw him on the floor by the window and called for help. The aide indicated she gave the resident orange juice and assisted the resident to eat his breakfast after the nurses had checked him.</p> <p>CNA #1 said the resident had a white area on his hand with brown "grill" marks and she thought it looked like a burn but she wasn't sure. The aide indicated the resident did not complain of pain.</p> <p>LPN #2, who was working on 1/18/11 was interviewed on 3/8/11 at 3:00 p.m. LPN #2 indicated at</p>						

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	<p>around 8:00 a.m., the charge nurse, who was working on Resident's B's hall, was on the phone, and she responded to a call for help in Resident #B's room.</p> <p>LPN #2 indicated the medical record's person was in the room and told her Resident #B's hand had been in the heater but when she checked his hand it did not look like a burn because there was no redness, swelling or blisters and appeared to be scar tissue. LPN #2 indicated she checked the resident's range of motion and helped him into the wheelchair while the charge nurse, LPN #3, took his vital signs and blood sugar. LPN #2 indicated, after she left the room, she did not see the resident again until he returned from his office appointment.</p> <p>The DON (Director of Nursing) was interviewed on 3/9/11 at 9:00 a.m. She indicated she had just started employment at the facility and on 1/18/11, it was her second</p>						

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	<p>day of orientation. The DON indicated she and the corporate nurse were in the facility, but were not made aware of the incident that occurred at 8:00 a.m. until after the resident left for an appointment at the orthopedic clinic. The DON indicated the medical record/van driver called the corporate nurse and told her she was with the resident at orthopedic clinic and he had a burn on his hand. The DON indicated the corporate nurse gathered up some supplies and she drove with the corporate nurse to orthopedic clinic. The DON indicated the corporate nurse applied some ointment and wrapped the resident's hand. She indicated she did not see the hand because she was talking to the doctor about the resident's foot.</p> <p>The DON indicated she did not examined the resident's right hand until he returned from the appointment at around 11:30 a.m. She indicated, when she looked at the hand, she recognized he had a</p>						

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	<p>third degree burn. The physician was notified and the resident was sent to the hospital. The DON indicated no treatment order was obtained prior to the administration of the ointment at the orthopedic clinic and the DON was unsure what ointment was used. The corporate nurse was no longer employed by the corporation.</p> <p>The charge nurse, LPN #3, who worked on Resident #B's hall on 1/18/11, was interviewed on 3/9/11 at 11:00 a.m.</p> <p>LPN #3 indicated she gave Resident #B 4 units of insulin coverage at around 7:00 a.m. and at around 8:00 a.m. she was on the phone when she heard the medical records person call for help. She responded to Resident #B's room and found him diaphoretic. His blood sugar was 51, she gave him a protein drink and took his vital signs three times with the last check being at 8:30 a.m.. LPN #3 indicated she heard the medical</p>						

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	<p>record staff person say Resident #B's hand had been on the heater but she did not look at his hand. LPN #3 indicated she left the room when the aide started feeding the resident. She indicated she did not recheck the resident's blood sugar, did not check the resident's hand and did not see the resident before he left for his appointment.</p> <p>Hospital records, dated 1/18/11, indicated Resident #B was admitted to the hospital with a full thickness burn of the right hand. The hospital discharge summary, dated 1/21/11, indicated the resident was discharge to a nursing facility following excision and debridement of a full thickness wound of the right hand. The resident was to continue on wound vac therapy with follow up in the burn clinic prior to grafting.</p> <p>The policy for hypoglycemia, revised 11/08, provided by the DON was reviewed on 3/9/11 at</p>						

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	<p>3:30 p.m., and indicated the purpose of the policy was "To detect an acute hypoglycemic episode as soon as possible and initiate immediate management of the episode. A diabetic ...resident/patient with blood glucose below 70 mg/dl or experiencing signs or symptoms of hypoglycemia is evaluated to determine if treatment is needed unless physician orders specify different parameters...</p> <p>5. Check blood glucose approximately 15 minutes after treatment...</p> <p>6. Notify physician of hypoglycemic episode for possible orders...</p> <p>9. Observe resident/patient for signs of (sic) symptoms of hypoglycemia..."</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 3/10/11 and began on 1/18/11. The Administrator and Director of</p>						

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	<p>Nursing were notified of the Immediate Jeopardy on 3/10/11. The Immediate Jeopardy was removed on 3/14/11, but the facility remained out of compliance at the level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Based on observation, interview, and record review, the facility removed the immediate jeopardy as follows: by providing staff with inservices regarding diabetic management, identification of burns and circumstances requiring notification of the physician; by assessing current residents for blood sugars outside the normal parameters; by assessing all residents who might be at risk for burns; and by updating care plans to reflect the assessed needs of diabetic residents and residents at risk for burns.</p> <p>Finally, the facility planned to provide ongoing monitoring of resident receiving insulin to assure</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2011

FORM APPROVED

OMB NO. 0938-0391

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	appropriate treatment and services were provided. This federal tag relates to Complaint Number IN00086999. 3.1-37(a)						

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F0323 SS=L	<p>Based on observation, interviews and record review:</p> <p>A. The facility failed to assure heating units were operating at a safe temperature. This resulted in a resident sustaining a burn requiring hospitalization. This deficient practice affected 1 of 1 residents with a burn in a sample of 7 and potentially affected all 49 residents residing in the facility. (Resident #B)</p> <p>B. The facility also failed to assure a resident was transferred safely using a hoist lift. This deficiency affected 1 of 1 residents, observed being transferred with a lift in a sample of 7. (Resident #U)</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 3/10/11 and began on 1/18/11. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 3/10/11 at</p>			F0323	<p>F 323 SS=L Free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents 1. The facility is unable to apply specific corrective action as the resident identified no longer resides in the facility. Each base board heater will be assessed by hovering hand immediately above the base board heater every hour on March 10, 2011 onwards to identify if the top of the heater is too hot to touch. In the event that the heater is hot to touch the person monitoring the heaters will contact the Supervisor to evaluate the thermostat and the heater and will turn down the thermostat as indicated. The Thermostats have been secured with a cover. The person monitoring the heaters, the Maintenance Director and the Administrator each have a key to the thermostat cover. The Base Board heater and the thermostat in each residents room has been assessed by the Maintenance Director on March 10, 2011. Base Board Heaters and Thermostats in each resident's room in need of replacement will be replaced by March 13, 2011. Completed. We have identified 5 of 47 residents who are a fall risk, one of which is diabetic. Those heaters and thermostats will be replaced first. Completed. On March 11, 2011, a HVAC Licensed Contractor</p>		04/13/2011

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	<p>2:30 p.m.</p> <p>The Immediate Jeopardy was removed on 3/14/11, but the facility remained out of compliance at the level of pattern, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>A. During interview on 3/8/11 at 9:45 a.m., during the entrance conference, the Administrator indicated there had been a reportable incident involving resident #B in January, 2011. The Administrator indicated Resident #B had a low blood sugar, fell and burned his hand on the heater in his room. The Administrator indicated the resident had been sent to the hospital burn unit and did not return to the facility.</p> <p>On 3/8/11, during the orientation tour, accompanied by the DON (Director of Nursing) all heating</p>				<p>evaluated the heating system and is developing a prototype to cover the heaters with an insulated product that will decrease the heat when touching the heaters. The HVAC Licensed Contractor has presented his findings to the Vice President of Plant and Operations for review on March 11, 2011, and a prototype is in the process of being developed for trial by Tuesday March 15, 2011. If successful the prototype will be made for each heater and may be in place by March 18, 2011. Addendum: 3/14/2011, facility has turned the baseboard heat completely off at the breaker and we are currently working with Rossworn HVAC for the completion of the register covers. 2. Residents who are insulin dependant diabetics have been identified. 15 out of 15 insulin dependant diabetic residents had their blood sugar checked and residents whose blood sugar was not within normal limits were referred to the physician for further review as indicated on March 10, 2011 and their insulin orders were adjusted if needed. 15 out of 15 insulin dependant diabetic residents had their insulin orders with parameters reviewed by the Nursing Management Team on March 10, 2011. 3 out of 3 glucometers had their calibration checked by the Director of</p>		

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	<p>units were checked on the east and south halls. Heating units in Rooms 135, 139 and 141 were found to be very hot to touch. The room thermostats were in a plastic enclosures that required a key to unlock. The thermostat dial was missing on the thermostat in room 135. The thermostats in rooms 141 and 139 were set at 65 and 75 respectively.</p> <p>The clinical record of resident #B was reviewed on 3/8/11 at 11:00 a.m.</p> <p>On 1/18/11 at 8:00 a.m., Nursing notes indicated, "Called to room per CNA et (and) med. (medical) records. Observed res. (resident) on floor between bed and window Rt (right) hand up against the register. Full ROM (range of motion). No c/o (complaints) of pain. res assisted back to w/c (wheelchair) et charge nurse entered room et began v/s (vital signs). Hand appeared s (without) redness was hard white area between thumb et 1st finger."</p>				<p>Nursing or designee on March 11, 2011 and each glucometer were identified as being calibrated correctly on March 11, 2011. 3 out of 3 med carts were reviewed by the Director of Nursing or designee to ensure that each insulin vial was dated and was current. 47 out of 47 residents had a skin assessment completed by March 11, 2011 and there were no other residents identified with a burn.</p> <p>Baseboard heaters replaced in all resident rooms and new heater covers currently being installed Baseboard heaters in hallways turned off and will be removed by POC date. Resident diabetic care plans were reviewed and revised as indicated by March 11, 2011. Care plan reviewed or revised if indicated for residents requiring assistance with lifting and transfers. 3. The facility administrator conducted education with 2 of 2 staff assigned only as hourly rounder on how to checking the heaters. 8 out of 10 department managers were trained on procedure for implementing appropriate interventions if needed for promotion of resident safety on 3/13/2011 The remaining department managers will be trained prior to commencing their next shift. 67 out of 71 employees (this includes department managers and contracted services – therapy, laundry</p>		

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	<p>Hospital records, dated 1/18/11, indicated Resident #B was admitted to the hospital with a 3rd degree full thickness burn of the right hand.</p> <p>The hospital discharge summary, dated 1/21/11, indicated the resident was discharge to a nursing facility following excision and debridement of a full thickness wound of the right hand. The resident was to continue on wound vac therapy with follow up in the burn clinic prior to grafting.</p> <p>On 3/8/11 at 2:10 p.m., CNA #4 was interviewed regarding the heating units. He indicated the day after the incident with Resident #B, on (1/19/11), he was getting a resident up in room #110 on the west hall, smelled smoke and found a pillow laying on the register. The CNA indicated there was a burn mark on the pillow and he showed the burned pillow to the staff who had gathered for the morning</p>				<p>Housekeeping staff) have been trained on March 14, 2011, on how to identify and recognize when the heaters are too hot, to notify the supervisor. The remaining employees will be trained by the Administrator or designee prior to the commencement of their shift. Omnicare Pharmacy Clinical Nurse Consultant conducted onsite training to DON, and Regional Quality Specialist on Diabetic management on March 11, 2011. DON and Regional Quality Specialist (RQS) re-educated licensed nursing staff on Diabetic Management, Facility policy & procedure related to diabetic management and when to notify physician related to diabetic management. The DON or designee will continue ongoing training with licensed staff and new hired licensed staff on orientation. The Director of Nursing and the Regional Quality Specialist have trained 14 out of 14 Licensed Nurses on March 14, 2011 on identification of burns and prompt notification of the Physician and/or DON. Managers and Licensed staff have been reeducated and trained on how to identify and recognize when heaters are too hot, and on notification process. Licensed nurses have re-educated nursing assistants (CNAs) on facility Policy and procedure regarding Electric and Hydraulic lifting</p>		

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	<p>meeting. The CNA indicated they "cut the heaters down," and started 15 minute checks.</p> <p>During interview on 3/9/11 at 11:30 a.m., the Maintenance Director indicated, after the incident on 1/18/11, he determined six thermostats were not working properly, including the thermostat in Resident B's room. He indicated he turned off the thermostat in resident #B's room but the unit continued to heat. He replaced all six thermostats, enclosed all of the thermostats in the rooms and put new covers on two of the heating units. He indicated he had an ongoing problem with the heating units being too hot or too cold and would check thermostats every day because of complaints but he did not keep records of which units were checked until after the incident.</p> <p>On 3/9/11 at 4:30 p.m., the electric heating unit in room 139 was noted</p>				<p>devices and 1 & 2 person assist transfers for Resident U and all other residents needing assistance with lifting and transferring. The Administrator or designee will do random rounds daily to ensure that the base board heaters are safe. Any heaters that are out of compliance will be addressed immediately. The DON or designee will review the 24 hour report for any changes in condition or incident through the daily clinical meeting and additional assessments will be completed as indicated.</p> <p>4. The DON or designee will review the 24 hour report for any changes in condition or incident through the daily clinical meeting and additional assessments will be completed as indicated.</p> <p>Addendum: The DON or designee will conduct QA rounds 3x's weekly for 4 weeks, weekly for 4 weeks, and then monthly thereafter, to ensure that diabetic residents have parameters for management of hypo and hyperglycemia, that the appropriate action has been completed by nurse related to FBS and daily finger sticks and that MD has been notified per policy.</p> <p>Addendum: DON or designee will conduct QA rounds 3x's weekly for 4 weeks, weekly for 4 weeks, and then monthly thereafter, of residents skin</p>		

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	<p>to be hot. The temperature of the unit was checked and found to be 218 degrees Fahrenheit. The thermostat in the room was set at 64 degrees Fahrenheit and the room temperature was 77 degrees Fahrenheit. The Administrator was notified and during interview at that time indicated the thermostat would be changed.</p> <p>On 3/10/11 at 9:00 a.m., the Administrator indicated, after the incident on 1/18/11, all thermostats were checked and six were not working properly, including the one in Resident #B's room. On 1/19/11 all six thermostats were replaced. The Administrator indicated prior to 1/18/11 the thermostats were checked on an ongoing basis and in response to complaints about the room temperatures but nothing specific was documented and as result they were not sure when resident B's room thermostat had been checked last. In addition, the administrator indicated, after the</p>				<p>to determine if any burn like concerns are noted.</p> <p>Addendum: The DON or designee will conduct observation of resident transfers during care, daily to 3x's weekly for 4 weeks, weekly for 4 weeks, and then monthly thereafter, to determine C.N.A proficiency in transfers and safety.</p> <p>Addendum: The DON or designee will will observe C.N.A's through return demonstration and verbalization regarding lifting and transferring procedures 3x's weekly for 4 weeks, weekly for 4 weeks, and then monthly thereafter.</p> <p>The results of these QA rounds will be addressed immediately by the DON or designee and reviewed at the Facility Risk Management Quality Improvement (RMQI) program for evaluation and revisions as indicated.</p> <p>Completion date: April 13, 2011</p>		

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	<p>incident on 1/18/11, the heating units were checked by a heating company and the thermostats were covered with a locked plastic enclosure so that the temperature setting could not turned up too high.</p> <p>On 3/10/11 at 9:05 a.m., three rooms on the south hall were checked. The electric heaters in room 124, 125 and 126 were very hot to touch.</p> <p>Resident #D, who resided in one of the rooms, and who was identified as interviewable, indicated her room was too hot and she had to open the window. The thermometer in the room was set at 52 degrees Fahrenheit.</p> <p>Resident #D said it was hard to regulate the temperature in the room and it was either too hot or too cold.</p> <p>B. On 3/9/11 at 5:45 a.m., CNA #4 was observed transferring</p>						

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	<p>dependent Resident #U from the bed to the wheelchair using a hooyer lift.</p> <p>The CNA did not obtain assistance and was the only staff person in the room during the transfer.</p> <p>On 3/9/11 at 1:00 p.m., the DON was asked about the transfer of Resident #U and indicated two staff persons should be present while transferring a resident using a hooyer lift.</p> <p>Resident #U's care plan, dated 12/24/10, was reviewed on 3/10/11 at 9:00 a.m. and indicated the resident was at risk for falls related to bilateral below the knee amputations and was to use a hooyer lift for transfers.</p> <p>The procedure for lift devices, revised 6/08, provided by the DON, was reviewed on 3/10/11 at 9:00 a.m. and indicated "...3. Review any special precautions or approaches to take</p>						

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	<p>when transferring a resident/patient. Obtain assistance as needed..."</p> <p>The procedure did not specify that two persons were required for a hoyer transfer.</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 3/10/11 and began on 1/18/11. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 3/10/11 at 2:30 p.m.</p> <p>The Immediate Jeopardy was removed on 3/14/11, but the facility remained out of compliance at the level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Based on observation, interviews and record review, the facility removed the immediate jeopardy as follows: by inspecting the heaters in each room and installing new electric heaters and thermostats in all resident rooms; by turning off</p>						

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	<p>installed heaters pending the installation of insulated protective heater covers; by inservicing staff regarding the need to monitor heating units in resident room for safe operational temperatures, by identifying resident's who were at risk of sustaining burns on the heaters and developing plans to protect theses residents. Finally, the facility planned to provide ongoing monitoring of heating units for any potential hazards.</p> <p>This federal tag relates to Complaint Number IN00086999.</p> <p>3.1-45(a)(1)</p>						

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F0425 SS=D	<p>Based on observation, interview, and record review, the facility failed to dispose of expired insulin. This deficiency affected 1 of 15 diabetic residents, whose insulin was observed. (Resident #R)</p> <p>Findings include:</p> <p>On 3/9/11, between 5:00 a.m. and 5:30 a.m., the expiration dates of insulin stored on three medication carts was observed with LPN #5. Novolin R insulin, used for Resident #R, was dated as opened on 2/3/11. LPN #5 was interviewed on 3/9/11 at 5:30 a.m., and indicated insulin expired 30 days after being opened and as a result, Resident # R's insulin should have been disposed of on 3/5/11. LPN #5 indicated</p>			F0425	<p>F 425 SS=D Pharmaceutical SVC-accurate procedures 1. Expired Insulin discarded and replaced for Resident R. All insulin vials checked for expiration dates and replaced as indicated. 2. The DON has completed glucometer Calibration for accuracy on all glucometer machines. The DON QA Insulin Vials to ensure dates are clearly identified and current on all Medication carts. 3. The DON re-educated nursing staff on the storage, disposal of expired insulin per pharmacy policy and recommendations. Insulin vials continue to be QA daily by DON or designee 4. Addendum: DON or designee will do QA reviews 3 x weekly for 4 weeks, once weekly for 4 weeks then monthly thereafter to ensure the Licensed Nurses are able to demonstrate and verbalize the appropriate measures regarding the demonstration, parameters, storage and disposal of insulin. Addendum: The results of these QA review will be addressed immediately by the DON or designee and reviewed at the Facility Risk Management Quality Improvement (RMQI) program for evaluation and revisions as indicated to prevent further occurrences Completion date: April 13, 2011</p>		04/13/2011

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NAME OF PROVIDER OR SUPPLIER RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER ROAD FORT WAYNE, IN46819			
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	<p>she would remove the insulin from the medication cart.</p> <p>The March 2011, medication administration record for Resident #R indicated her blood sugars were checked four times daily and Novolin R Insulin coverage was administered based on the Resident's blood sugar readings.</p> <p>Review of the diabetic flow sheets revealed Resident #R received Novolin R Insulin four times each day for sixteen doses between 3/5/11 and 3/8/11.</p> <p>The policy for insulin administration, revised 6/8, provided by the DON (Director of Nursing), was reviewed on 3/10/11 at 8:45 a.m., indicated "...Inspect the bottle for type of</p>						

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	<p>insulin and expiration date..."</p> <p>The pharmacy recommendations for insulin storage, dated 9/23/10, provided by the DON, was reviewed on 3/10/11 at 8:45 a.m., and indicated vials of Novolin R expired 28 days after being opened when refrigerated or when stored at room temperature.</p> <p>This federal tag relates to Complaint Number IN00086999.</p> <p>3.1-25(o)</p>						

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F0441 SS=D	<p>Based on observation, record review, and interview, the facility failed to assure 1 of 2 C.N.As observed for resident care, washed their hands between resident care in order to prevent the spread of infection.</p> <p>This deficiency affected 3 of 4 residents observed for personal care. (Residents #I, #J, #K)</p> <p>Findings include:</p> <p>1. During observation of resident care, beginning at 5:23 a.m., on 3/9/11, C.N.A #1 was observed performing personal hygienic care for residents on the West Hall.</p> <p>The C.N.A provided care to resident #I, who was laying in bed in her room. The C.N.A put on gloves, washed the resident's face, upper body, and completed peri care on the resident, after removing her incontinence brief, which was wet. She then applied barrier cream to the resident's buttocks area, and placed a new incontinent brief on the resident. C.N.A #1 then removed her gloves.</p> <p>Another C.N.A who had come into the resident's room, then assisted C.N.A #1 to transfer the resident, using a hoier lift, to the wheelchair.</p> <p>C.N.A #1 then re-applied the resident's oxygen cannula to the resident's nose, put</p>		F0441	<p>F 441 SS=D 1. DON conducted assessment of residents and no adverse consequences where noted post surveyor observation of staff member lack of hand washing for residents I, J, K. 2. DON or designee will conduct return demonstration of staff related to facility policy and procedure on hand washing. 3. DON or designee to re-educate licensed staff on facility policy and procedure infection control specific to hand washing. DON or designee will conduct random QA observation of hand washing. 4. ADDENDUM: DON or designee will observe C.N.A's 3 x weekly for 4 weeks, once weekly x 4 weeks, and then ongoing monthly for proper handwashing procedures. Addendum: The results of these QA rounds will be addressed immediately by the DON or designee and reviewed at the Facility Risk Management Quality Improvement (RMQI) program for evaluation and revisions as indicated to prevent further occurrences Completion date: April 13, 2011</p>		04/13/2011	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>glasses on the resident, took out the plastic bag of dirty laundry she had used for the resident's care, and placed it in the large garbage container in the hall, outside of the resident's room. The C.N.A then made the resident's bed, and brushed the resident's hair, then placed the call light within reach of the resident and left the room.</p> <p>The C.N.A had not washed her hands after doing personal care on Resident I, and proceeded to go to Resident J's room. She put on a clean pair of gloves, then took a clean basin, filled it with water in the resident's bathroom, removed the wet incontinence brief from the resident who was laying in bed. C.N.A #1 then washed the resident's peri area, applied barrier cream to her buttock's area, and left the resident in bed. She emptied the basin of water in the bathroom, removed her gloves, took out the bag of dirty laundry and placed it in the large garbage container in the hall. Without washing her hands, she was observed going down the hall, and bringing back another clean basin, then walked back to the same room she had just left, went to Resident #K's bathroom, (roommate of Resident #J) filled the basin with water, and donned a new pair of gloves. The C.N.A then removed Resident K's wet brief, washed her peri area, applied barrier cream to the</p>						

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	<p>resident's buttock's area, and applied a clean brief.</p> <p>The C.N.A then removed her gloves , took the dirty plastic bag with the soiled laundry outside the resident's room and placed it in the large garbage container, in the hall, and walked down the hall, without washing her hands.</p> <p>Review of the "INFECTION CONTROL MANUAL" for "Infection prevention" regarding hand washing, provided by the Director of Nursing (DON), on 3/10/11, the revised date indicated 2/09.</p> <p>The policy indicated the facility required personnel to wash their hands thoroughly to remove dirt, organic material, and transient microorganisms. The policy indicated, "handwashing is mandated between resident/patient contact in an effort to prevent the spread of infection. Hands must be washed after the following , including, but not limited to:</p> <ul style="list-style-type: none"> Contact with contaminated items or surfaces Contact with resident/patient Removal of gloves." <p>The DON was interviewed, at 10:18 a.m., on 3/10/11. She indicated a corporate nurse had identified a concern with a staff member not washing their hands appropriately, during a visit to the facility</p>						

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	<p>in February, 2011. The DON indicated an inservice was done on Infection control after the corporate nurse identified the concern.</p> <p>Review of an attendance log, dated 1/31/11, regarding an inservice on Infection control, indicated C.N.A. #1 had signed the attendance log indicating she had attended the inservice.</p> <p>This federal tag relates to complaint # IN00087008</p> <p>3.1-18(I)</p>						